American Indian Health and Family Services of Southeast Michigan's
Manidookewigashkibijigan Sacred Bundle: R.E.S.P.E.C.T. Project

Part 1 - GATEKEEPER’S Early Identification and Referral Survey

Gatekeeper Information

1. Gatekeeper Name: ____________________________
   First Name (please print)       Last Name (please print)

2. Date Part 1 – Survey completed: _____ _____/ _____ _____/ _____ _____
   Month                          Day                           Year

3. Gatekeeper’s current Email Address: ___________________________________

4. Gatekeeper’s current Phone Number: ___________________________________

5. What gatekeeper training have you received? (Please check all that apply)
   ____ 1= QPR (Question, Persuade and Refer)
   ____ 2= ASIST (Applied Suicide Intervention Skills Training)
   ____ 3= safeTALK (suicide alertness for everyone, Tell, Ask, Listen and Keep Safe)
   ____ 4= Other. Please specify: ____________________________________________

Early Identification Information

6. Date: (Date of Identification): _____ _____/ _____ _____/ _____ _____
   Month                          Day                           Year

7. Sources of information used to complete this form (Check all that apply).
   __ Case record review or existing data system
   __ Directly from a provider (i.e., case manager, clinician, mental health professional)
   __ Directly from a gatekeeper (i.e., not a mental health professional)
   __ Other (Please describe: ________________________________________________)

8. Early Identification Activity Setting (Check only one)
   ____ 1=School
   ____ 2=Child Welfare
   ____ 3=Juvenile Justice
   ____ 4=Law Enforcement
   ____ 5= Community-based organization, recreation or after school activity
   ____ 6=Physical Health
   ____ 7=Mental Health Agency
   ____ 8=Home
   ____ 9= Emergency Room
   ____ 10= Other (Please describe: __________________________________________)
8a. Where did the identification take place? (Please check only one)
   _____ 1= at an American Indian Health & Family Services (AIHFS) partnering agency
   _____ 2= at AIHFS’s Behavioral Health (BH)
   _____ 3= at AIHFS’s Medical Clinic
   _____ 4= at one of AIHFS’s other programs other than BH or the Medical Clinic
   _____ 5= at a community gathering at AIHFS
   _____ 6= at a powwow not held at AIHFS
   _____ 7= at a University or College Campus
   _____ 8= at a community gathering not held at AIHFS
   _____ 9= at home
   _____ 10= Other (e.g., facebook or twitter) Please specify: ____________________

8b. In what county did the identification take place?
   _____ 1= Wayne County
   _____ 2= Oakland County
   _____ 3= Macomb County
   _____ 4= Washtenaw County
   _____ 5= St. Clair County
   _____ 6= Livingston County
   _____ 7= Monroe County
   _____ 8= Other. Please specify: ____________________

9. Source of Early Identification of Youth (Please check only one):
   _____ 1= screening (select only if youth was identified at-risk at the conclusion of the entire screening – e.g. post-screening interview or debriefing process)
   _____ 2= Parent/Foster Parent/Caregiver
   _____ 3= Mental health service provider (e.g., clinician, school counselor, etc.)
   _____ 4= Teacher or other school staff (including college or university staff)
   _____ 5= Community based organization, recreation or after school program staff
   _____ 6= Child welfare staff
   _____ 7= Probation officer or other juvenile staff
   _____ 8= Primary care provider (i.e., pediatrician)
   _____ 9= Emergency room staff
   _____ 10= Police officer or other law enforcement staff
   _____ 11= Peer
   _____ 12= Other (Please describe – e.g. “self” _________________________)

Demographic Information

10. What is youth’s age? ___ ___ years

11. What is youth’s gender? (Please check only one)
   _____ 1= Boy
   _____ 2= Girl
   _____ 3= Transgender
   _____ 4= Other (please specify: ____________)
   _____ 5= Information on gender is missing
12. Is the youth of Hispanic or Latino cultural/ethnic background?
   ____ 1= Yes Hispanic/Latino
   ____ 2= No [Skip to item 13]
   ____ 3= Information on Hispanic ethnicity is missing

12a. [IF YES] Which group describes his/her Hispanic or Latino cultural/ethnic background? Is he/she (Check all that apply)?
   ____ 1= Mexican, Mexican-American, or Chicano
   ____ 2= Puerto Rican
   ____ 3= Cuban
   ____ 4= Dominican
   ____ 5= Central American
   ____ 6= South American
   ____ 7= Hispanic origin in local MIS (Management Information System) but not represented in list above (Please specify: __________________________)

13. Which group(s) describes the youth? Is he/she (select all that apply)?
   ____ 1= American Indian or Alaskan Native
   ____ 2= Asian
   ____ 3= Black or African American
   ____ 4= Native Hawaiian or Other Pacific Islander
   ____ 5= White
   ____ 6= No race available (Please describe: __________________________)

**Referral Information**

14. Was the youth referred for either non-mental health or mental health related services?
   ____ 1= Yes [Skip to item 15]
   ____ 2= No

14a. [IF NO] Why was the youth not referred to any type of services? (Select the ONE primary reason).
   ____ 1= youth was already receiving mental health services
   ____ 2= no capacity at provider agencies to receive a mental health referral
   ____ 3= youth already receiving other supports. If so, please describe those supports: __________________________
   ____ 4= youth determined not to be at risk during referral process (for example, if a mental health professional interviews a youth identified by gatekeeper and determines that they are not at risk for suicide and do not need a referral for further mental health services)
   ____ 5= Other (Please describe: __________________________)

**IF NO REFERRAL MADE, END SURVEY!**

Please turn in this survey to Christy Bieber, GLS Sacred Bundle Project Coordinator.

15. Were non-mental health related supports recommended for the youth?
   ____ 1= Yes
   ____ 2= No [Please skip to item 16]
15a. [IF YES] Type of non-mental health recommendations (Please check all that apply).
   ______ 1=Informed youth of the crisis hotline
   ______ 2=Discussed availability of other supports with youth (i.e. talk with teacher, 
   family member, etc.)
   ______ 3=Tutor/academic counseling
   ______ 4=Recreational/afterschool activities
   ______ 5=Primary care or physical health referral (e.g. medical, vision, hearing, 
   dental)
   ______ 6=Other (Please describe:________________________________________)

16. Was the youth referred for mental health related services?
   ______ 1=Yes [Continue with Questions 16a and 16b on next page]
   ______ 2=No  If NO to Question 11 STOP THE SURVEY and 
   PLEASE TURN IN YOUR FORM TO Christy Bieber, Sacred Bundle 
   Project Coordinator.

16a. [IF YES] Date of referral for mental health services:
   ______ ____ / ____ ____ ____ ____
   Month                        Year

16b. [IF YES] Where was the youth referred for mental health related services (Please 
   check all that apply).
   ______ 1= Public Mental Health Agency or Provider
   ______ 2= Private Mental Health Agency or Provider
   ______ 3= Psychiatric Hospital/Unit
   ______ 4= Emergency Room
   ______ 5= Substance Abuse Treatment Center
   ______ 6= School Counselor
   ______ 7= Mobile Crisis Unit
   ______ 8= Other (Please describe:________________________________________)